UM Department Request Form ~ BCBSMA

Today's Date: _____/_____/_____ **Authorization #** _____

Patient Name: _____ **Patient ID #** _____

Practitioner Name: _____

Instructions:
1. Please fax this form to WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC @ **(888) 492-1029.**
2. Please complete **one section only** and **check one box only** prior to submission.
3. If you have any questions please call WHN @ **(866) 656-6071.**

Extension of Authorization End Date: 10 Days ☐ 20 Days ☐ 30 Days ☐
*Request to extend treatment timeframe **(end date)** on visits previously authorized but not yet utilized.*

Please Note: One (1) date extension will be considered per episode of care with a maximum of thirty (30) days. Request must be received within 30 days from end date of prior authorization.

Request for a Peer to Peer Discussion: ☐

Within 180 days from receipt of an adverse determination, you may request a discussion with the peer reviewer who made the decision. A reviewer will be available within one business day of receipt of the request.

Phone number: _____

Best days & times to call: (Option 1) _____ (*Day*) /_____ (*Time*) (Option 2) _____ (*Day*) /_____ (*Time*)

Please Note: We attempt to accommodate best options to call but cannot guarantee the time for the call.

Provider request for a Reconsideration of a Medical Necessity Determination: ☐

Within 180 days from receipt of an adverse determination for a prospective or concurrent review, you have the right to have the case reviewed by a peer reviewer other than the one that made the original determination.
You may provide any additional clinical documentation which may support your reconsideration request.

Reconsiderations will be completed within one (1) business day.

Provider request for an Appeal of a Medical Necessity Determination: ☐

Within 180 days from receipt of an adverse determination for a retrospective review, you have the right to have the case reviewed by a peer reviewer other than the one that made the original determination.
You may provide any additional clinical documentation which may support your appeal.
We will notify you of our decision by letter within 30 days of the receipt of your request for an appeal.

Total pages if additional medical records are being submitted _____

Please Note: Your patient may have certain grievance or appeal rights available through the Blue Cross Blue Shield of Massachusetts Grievance Program and any such rights will be communicated directly to BCBSMA Patients.